Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH TEXAS PAIN RECOVERY
6702 W POLY WEBB RD
ARLINGTON TX 76016

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

AMERICAN EMPLOYERS' INSURANCE

Carrier's Austin Representative Box
Box Number 29

MFDR Received Date
December 30, 2003

MFDR Tracking Number
M4-04-4707-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "*Also dates of service 9/22/03 to 9/26/03 were also listed incorrectly on the 'TABLE OF DISPUTED SERVICES." The carrier paid for the services on these dates per the applicable fee guidelines.* We are basing this dispute on the following information. The interdisciplinary chronic pain management program was billed with a global all-inclusive hourly fee of $175/hr. The fee included the following services: medical direction and medical management, physical therapy (including passive modalities, such as E-STIM, ultrasound, whirlpool and massage, and active modalities, including aquatic therapy and exercises to increase range of motion, flexibility, strength and endurance), educational psychological services, biofeedback training, hypnotherapy, individual counseling, group counseling, and case management. The services were provided by a highly trained and qualified professional staff including a physician, physical therapist, rehabilitation technician, psychologist, rehabilitation counselor, alcohol and drug abuse counselor, social worker, and family therapist… I am also enclosing the results of a survey we conducted in 2001 and 2002 on the MAR other insurance companies paid for 97799 AP CP… The carrier might suggest that their fee of $115/hr. was sufficient since TWCC set the fee for 97700 AP CP at $125 on 8/1/03, however I would disagree. Prior to 8/1/03 we had more intensive clinical programming, as well as a larger staff designed to give the patients more individual treatment. Since the fee has been lowered to $125/hr we have changed our programming (less individual treatment) and our staff was reduced… to reconcile our treatment costs with the reduction in fees.."

Amount in Dispute: $21,395.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has previously paid the charges covered the 1996 MFG at a fair and reasonable rate.".

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2003 July 3, 2003 July 8, 2003 July 9, 2003 July 10, 2003 July 14, 2003 July 15, 2003 July 16, 2003 July 17, 2003 July 18, 2003 July 24, 2003 July 25, 2003 July 28, 2003 July 29, 2003 July 30, 2003 July 31, 2003 August 1, 2003	CPT Code 97799-CP	$21,395.00	$1,320.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets out the procedures for fair and reasonable reimbursement.
3. 28 Texas Administrative Code §134.202 sets out the medical fee guideline for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 31, 2003, August 6, 2003, August 14, 2003, August 21, 2003, September 3, 2003
   - 510 – Payment determined
   - M – No MAR

Issues

1. Did the requestor support their request for additional fair and reasonable reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. In support of the requested reimbursement, the requestor submitted the results of a survey the requestor conducted in 2001 and 2002 on the MAR other insurance compaies paid for CPT Code 97799-AP-CP. The requestor also stated that the analyses of these figures show the mean (average) fee paid by the insurance companies was $138; the median fee was $131.00, while the mode (most frequent) fee paid by these insurance companies was $138. The carriers' reimbursement methodologies are not described by the requestor in their survey results.

   1996 Medical Fee Guideline, Medicine Groud Rule (II)(C) indicates if the Requestor is a CARF accredited program modifier AP would be applied. If the Requestor were not a CARF accredited program then 20% reduction would be applied. The Requestor is CARF accredited and has attached modifier AP so billing is not subject to the 20% reduction for dates of service July 2, 2003 through July 31, 2003.

   On June 11, 2003, a Travis County District judge issued a final judgment, stating that the MFG was valid and applicable for professional medical services provided on or after August 1, 2003. On July 29, 2003, the judge denied the motion for a new trial and kept the effective date as August 1, 2003.

For date of service August 1, 2003, 28 Texas Administrative Code §134.202(e)(5)(E)(ii) *(effective Jauary 15, 2003, 27 Texas Register 12304)* was the applicable guideline and reimbursement shall be $125.00 per hour.

2. Review of the submitted documentation finds that reimbursement is due. Therefore, the billed amount of $125.00 per hour x 132 billed hours = $16,500.00 - $15,180.00 (Carrier payment) = $1,320.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,320.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,320.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		August 2, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.